LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any deficiency statement ending with an esterisk (\*) denotes addictioncy which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are clied, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Provious Versions Obsolele

Event ID: UK1Z11

Facility ID: 100299

2707268706

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185313	B. WIN	10 —		10/	14/2010
	ROVIDER OR SUPPLIER	REHAB CENTER, INC		68	EET ADDRESS, CITY, STATE, ZIP CODE 13 E. THIRD STREET USSELLVILLE, KY 42278		
(X1) IĎ PREF¦X TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF	ix	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SKONLD 8É	(X5) COMPLETION DATE
F 164	This REQUIREMENT by: Based on observation reviews, it was detern ensure the provision ensuring the privacy care for three resider selected sample of 1s in the selected sample A review of the facility of Nursing Home Residated, revealed nursi right to privacy in me to be treated equally  1. A record review re admitted to the facility quarterly Minimum D 09/28/10, revealed th #1 as cognitively inde extensive assistance transfers. The MDS r indwelling catheter ar An observation, on 1s staff did not ensure p wound/catheter care the privacy curtain. T resident was visible to resident's room.  Interviews with Licen #1, on 10/13/10 at 1: Aide (CNA) #1, on 10 respectively, revealed	is not met as evidenced  as, Interviews and record mined the facility failed to of personal privacy by curtains were pulled during ats (#1, #6 and #8), in the d and one resident (#20), not e. Findings include;  and one resident (#20), not e. Findings include;  and one resident (#20), not e. Findings include;  and one resident and the dical treatment and the right and with dignity.  and with dignity.  and one resident #1 was y on 07/19/10. A review of a sala Set (MDS), dated e facility identified Resident expendent and required with bed mobility and evealed the resident had an and was incontinent of bowel.  and one resident #1, by pulling the curtain was open and the or anyone entering the  sed Practical Nurse (LPN) 10 PM and Certified Nurse	F		related to the requirement to p personal privacy with an emph- use of privacy curtains to provi privacy during care. This educ- conducted by the Administrato Staff Development Coordinator Further re-education related to requirement to provide persons use of privacy curtains during if will be provided to all nursing a nursing assistants, medication licensed nurses not previously training sessions scheduled fro 10/25/10. Training will be cont staff who have not been trained 11/12/10. This training will be coordinated by the Staff Develo Coordinated by the Staff Develo Coordinator. Any person not tr 11/12/10 will be trained on the scheduled day of work before to their shift. The staffing coordin be responsible for arranging or training to anyone scheduled to 11/12/10 who has not yet been  MOW CORRECTIVE ACTIONS MONITORED:  A 10% sample of residents will by the QA committee to be observed to the be determined by the C . The sample will include resid units and will be conducted on Designees from the QA commit include the Staff Development QA nurse, ADON, MOS Coordin and Administrator will be assig observe staff members providi sample of residents to verify th personal privacy by pulling privacy during care.	asis on the de visual action was ration was rand the visual action was rand the visual action was rand the visual action was rand to visual action was rationed in ma 10/13-inued with defined or opment valued by ir next peginning pator will visual reproviding o work after a trained.  WILL BE  be selected derived during visis provided. It was a visual ration of QA committee ents on all all shifts. It tee to Coordinator, actors, DON, and to ng care to the provision of	11/1.3/10

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PRINTED:	10/27/2010
FORM A	APPROVED
OMB NO.	0938-0391

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUCTION (X8) MULTIPLE CONSTRUCTION (X8) MULTIPLE CONSTRUCTION (X9) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		185913	8. WING _		10/14/2010
	ROVIDER OR SUPPLIER  DOD PLACE NURSING	rehab center, inc	1	REET ADDRESS, CITY, STATE, ZIP CODE 883 E. THIRO STREET RUSSELLVILLE, KY 42276	
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		id Prefix Tag	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 164	Continued From pag	e 2	F 164		,
	privacy was not provistated. "The privacy of pulled just in case so without knocking on the state of the facility in the quarterly MDS, discility identified Resigned pendent and required bed mobility.  An observation, on the privacy was not proving was not proving was not proving revision of wounder ont pulled and the resentering the resident."  An interview with LPP PM, revealed he did for Resident #6, because a roommate. He pulled the curtain bed walked in the room."  An interview with CN. PM, revealed she was someone to enter the wound care. She state should have been utilized to the facility quarterly MDS, dated facility identified Resident Resident Resident Resident Residentified Resident	revealed she realized ided for Resident #1. She curtain should have been meone entered the room the door."  vealed Resident #6 was y on 07/14/10. A review of ated 08/26/10, revealed the ident #6 as cognitively uired extensive assistance  0/13/10 at 9:40 AM, revealed ided for Resident #6 during are. The-privacy curtain was sident was visible to anyone is room during the care.  N #1, on 10/13/10 at 1:10 not pull the privacy curtain buse the resident id not estated, "I should have cause someone could have  A #1, on 10/13/10 at 1:40 is aware of the potential for eresident's room during ted the privacy curtain identification."			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUII	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	185313	B. WIN	G	And the state of the second se	10/	14/2010	
NAME OF PROVIDER OR SUPPLIER  CREEKWOOD PLACE NURSING & REHAB CENTER, INC		·	683	T ADDRESS, CITY, STATE, ZIP CODE E. THIRD STREET SSELLVILLE, KY 42276			
PREFIX (EACH DEFICIENCY M	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		×	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DITO BE	(X5) COMPLETION DATE	
and was frequently inco An observation, on 10/1 Registered Nurse (RN) personal privacy during assessment. The priva separating Resident #8 however, the curtain wa around the resident's be from anyone opening th room.  An interview with RN #/ revealed she thought be pulled.  4. A record review reve admitted to the facility de severely cognitively imp incontinent of bowel and extensive assistance of toileting.  An observation, on 10/1 revealed the resident's surveyor knocked on th opened the door and of Resident #20 was on a privacy curtain was not resident's bed to provid resident was exposed i roommate and anyone hallway.	ansfers. The MDS ad an indwelling catheter antinent of bowel.  I3/10 at 2:20 PM, revealed #1 did not ensure provision of a skin cy curtain was pulled from his/her roommate; as not pulled completely ed to ensure visual privacy as door or entering the  I, on 10/14/10 at 1:34 PM, oth curtains had been  sealed Resident # 20 was on 05/19/10. A review of assment, dated 08/15/10, antified Resident #20 as baired, frequently d bladder and required fitwo staff for transfers end  I4/2010 at 9:32 AM, door was closed. This are resident's door. CNA #2 beservation revealed bedside commode. The drawn around the le visual privacy. The	F	164				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
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AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		V. BOII		LE CONSTRUCTION	(X3) DATÉ SURVEY COMPLETED		
		105313	B. WIN	G		10/	14/2010
	OVIDER OR SUPPLIER	REHAB CENTER, INC		68	EET ADDRESS, CITY, STATE, ZIP CODE 33 E. THIRD STREET USSELLVILLE, KY 42278		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST 8E PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD SE	(X5) COMPLETION DATE
F 282	An interview with the 10/14/10 at 9:55 AM, to provide privacy and care. She stated, "It v privacy curtain in a refresident does not have 483.20(k)(3)(ii) SERV PERSONS/PER CART The services provided must be provided by accordance with each care.  This REQUIREMENT by: Based on interviews a determined the facility were provided in accordance with each for one resident (#9), 19. On 09/09/10, Refrom a shower bad in member was providin been assessed and cassistance of two staff Findings include:  A review of the facility "Comprehensive Care revealed "The plan of and will identify the regoals to be achieved, meet resident's needs	not pull the privacy curtain reain was very hard to pull.  Director of Nursing, on revealed she expected staff of pull privacy curtains during would be ideal to pull the esident's room, even if the rea roommate."  ICES BY QUALIFIED RE PLAN  dor arranged by the facility qualified persons in a resident's written plan of the selected sample of in the selected sample of in the selected sample of isident #9 sustained a fall the shower room. One staff of the bath. The resident had are planned for the fighth of the shower room.  It's policy/procedure, a Plans", dated 09/17/09, a care will be stated clearly esident problem, measurable which include timetables to so and the intervention to be oviding the resident care.	e ann a properties en mener personal properties en entre properties en entre properties en entre properties en	282	It is the normal practice of Cripiace Nursing and Rehab Cent ensure services are provided qualified personal in accordance each resident's written plan of CORRECTIVE ACTION FOR RESAFFECTED BY THIS PRACTICE:  Nursing staff responsible for provident (#9) were re-educated (9/9/10 by the ADON, DON, OA Nu Staff Development Coordinator to showers to resident (#9) with the of two staff members in accordance written plan of care.  Resident (#9) is receiving shower the assistance of two staff membaccordance with her written plan	ter to by ice with f cere,  IDENTS  Iding care d on rse, and provide assistance ce with her  rs with ers in	
	followed by staff in pro-	oviding the resident care.					Anne and the first Lagrangian

	of Deficiencies F Correction				(X3) DATE SURVEY COMPLETED		
		185313	B. WI	IG		10/	14/2010
	ROVIDER OR SUPPLIER	REHAB CENTER, INC		66	EET ADDRESS, CITY, STATE, ZIP CODE 33 E. THIRD STREET USSELLVILLE, KY 42278		
(X4) 1D PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(XS) COMPLETION DATE
,	responsible for the car A record review revea admitted to the facility diagnoses to include Late Effect Cerebrova. A review of the annual dated 08/17/10, revea resident as moderate required extensive as bed mobility and transand required total assibathing. Resident #9 from a past stroke and Plan, "Self Care Deficinterventions to includ with shower; shower to bath on in-between diagnostic for two staffs shower bed.  A review of the "Nurse A 08/18/10, revealed the assistance of two staffs shower bed.  A review of the nurse 9:30 AM, revealed Lic (LPN) #2 was summon observed Resident #9 the floor. Staff reported shower bed. The nurse alert and verbal and a on the left side of the knee. The resident was members from the floor a sheet. The resident and neuro-checks we	aled Resident #9 was a, on 01/15/07, with Urinary Trect infection and ascular Accident.  Il Minimum Data Set (MDS), aled the facility identified the dy cognitively impaired, sistence of two staff with afers, was non-embulatory distance of two staff with had left sided paralysis d was not interviewable.  Int's Comprehensive Care ait." dated 08/17/10, revealed le: "Total assistance of two two times per week; Partial ay; Uses shower bed." A Aide Data Sheet," dated	F	282	HOW OTHER RESIDENTS HAP POTENTIAL TO BE AFFECTED IDENTIFIED:  The written plan of care for curvas reviewed by the ADON and to identify residents requiring more than one staff member of the review was completed by MEASURES OR SYSTEMIC CONTROL OF PREVENT RECURRENCE:  Re-education was provided 9/5 9/20/10 and again 10/21/10 and 10/25 to staff including nursing assistechs, and ilcensed nurses on providing care in accordance versidents written plan of care the requirement to follow the pamount of assistance for the paths and showers.  Education will be provided upon staff including nursing assistantechs, and ilcensed nurses on residents written plan of care reviewing the NADS dally.  HOW CORRECTIVE ACTIONS MONITORED:  Unscheduled observations of sign providing assistance to residents assistance to residents assistance of more than one for were done 9/17/10 thru 10/19/ by designated members of the committee including the ADON nurse, MOS coordinator, and St Development Coordinator.  QA committee members including the ADON nurse, MOS coordinator, and St Development Coordinator.	rrent residents d OA nurse assistance of or showers. 9/15/10. HANGES TO  1/10 thru rru 10/16/10 /10 tants, med consistently rith each or reinforce planned rovision of  n hire to its, med following the and  WILL BE  telff members ts requiring r showers 10 QA , DON, QA aff	

PRINTED: 10/27/2010	
FORM APPROVED	
OMB NO. 0938-0391	
(3) DATE SURVEY	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185313	B. WINQ_		10/	14/2010	
	NOVIDER OR SUPPLIER	& rehab center, inc	3	TREET ADDRESS, CITY, STATE, ZIP COD 683 E. THIRD STREET RUSSELLVILLE, KY 42276			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	IN SHOULD DE E APPROPRIATE	(8X) COMPLETION PATA	
F 282	Further review of the approximately an hocomplained of chest the hospital at 10:45 by ambulance at 1:2  An interview with Ce on 10/13/10 at 9:15 assisted her to transchair to the shower the other staff she dithe resident's care passist with the was undered and two staff required for assist she stated she did review the intervention to the stated she had shower without assist An interview with LP PM, revealed the fact resident to require to daily living, except fall, the resident was to the hospital about of chest pain. The rethe same day, with a fracture.  An interview with the 10/14/10 at 10:45 Al not complain of pain	nurses' note revealed ur later, the resident pain and was transferred to AM. The resident returned	F 28	DON, QA nurse, MDS coordin Development Coordinator will randomly observe a minimur showers per week of resident more than one assist at unar for four (4) weeks, then a min showers per month for a peri determined by the QA comm Observations will include stat shifts (there are no schedule 3rd shift) and will be to verify staff assisting with the showe accordance with the resident of rare without deviation.  The QA committee may incref frequency or duration of obseconcerns are identified. Contareas of concern are identified frequency and duration of mobe decreased.  Continued education will be pincluding nurse techs, med to licensed nurses at a minimur for the next nine months and annually.	Il continue to m of ten (10) to then (10) to the tequire mounced times old of time to be littee. If on 12 and 2 <sup>rd</sup> d showers on the number of er is in experience of the cryations if versely, if no de the ponitoring may be or of death of the continue of quarterly.	10/26/10	

CREEKWOOD PLACE PAGE 09/17 11/15/2010 10:28 2707268706

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUK		CONSTRUCTION		(X3) DATÉ SURVEY COMPLETED	
		185313	B, WIN	g		10/1	14/2010	
	OVIDER OR SUPPLIER	REHAB CENTER, INC		683	ET ADDRESS, CITY, STATE, ZIP CODE E. THIRO STREET SSELLVILLE, KY 42276		HILOTO	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X8) COMPLETION DATE	
F 282 F 323 SS=D	after the fall, due to cook she stated CNA #4 havailable on the day to expected all CNAs to shift.  An interview with the 2:30 PM, revealed an immediately after the investigation revealed followed by CNA #4. review and follow the 483.25(h) FREE OF AHAZARDS/SUPERVIOLEMENT The facility must ensure environment remains as is possible; and earlied adequate supervision prevent accidents.	he hospital about an hour omplaints of chest pain. ad plenty of staff assistance he resident fell and she review care plans every administrator, on 10/14/10 at investigation was initiated resident's fall and the facility if the care plan was not She expected CNA #4 to care plans daily. ACCIDENT SION/DEVICES		323	F 323  It is the normal practice of Cre Place Nursing and Rehab Conte ensure the residents' environm remains as free of accident has is possible; and each resident is adequate supervision and assis devices to prevent accidents.  CORRECTIVE ACTION FOR RESID	erto lent tards as fecelves stance		
	determined the facility resident's environment accident hezards as preceived adequate su accidents for one resistantle of 19. According to the resident requirement in the shower recognition, Resident #8 shower bed in the shower	it remained as free of cossible and each resident		1000 - AMAZON 91 - AMAZON 21 - 12 - 12 - 12 - 12 - 12 - 12 - 12	AFFECTED BY THIS PRACTICE:  Nursing staff responsible for provide care to resident (#9) were re-educe 9/9/10 by the ADON, DON, OA nurse, and Staff Development Coorto provide showers to resident (#9) the assistance of two in accordance with her written plan of care to enhisafety.  Resident (#9) is receiving showers assistance of two staff members in accordance with her written plan of	ling ated on dinator with ance		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPL A. BUILDING	É CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185313	B. WING		10/	14/2010	
	ROVIDER OR SUPPLIER	REHAB CENTER, INC	68	ÉT ADDRESS, CITY, STATE, 21º CODE 3 E. THIRD STREET JSSELLVILLE, KY 42276		14,2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REPERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
F 323	Continued From page	e 8	F 323		V		
	dated 06/01/10, reversional dated of the completed and with significant of the resident's function specific form. Based preventive/safety mediane.	y's policy/procedure, "Falls", aled "The falls risk analysis upon admission, quarterly nange in condition affecting a status using the state on the analysis, asures will be implemented, sidents identified at risk for		HOW OTHER RESIDENTS: POTENTIAL TO BE AFFECT IDENTIFIED:  The written plan of care for c residents was reviewed by th the QA nurse to identify resid assistance of more than one for showers to promote safet; The review was completed by	red Were  urrent e ADON and lents requiring staff member y.		
	A review of the annual dated 08/17/10, reveal and required extensive with bed mobility and non-ambulatory and retwo staff with bathing. Ieft-sided paralysis from the resident was assively and the resident was assively and the resident was assively and the facility as high risk for falls.  A review of a falls risk revealed the facility as high risk for falls.  A review of the Comp "Self Cara Deficit" dat interventions included with shower, shower to shower bed." A review Sheet," dated 08/18/1	or, on 01/15/07, with Urinary Tract Infection and ascular Accident,  Il Minimum Data Set (MDS), alled the facility identified rately cognitively impaired assistance of two staff transfers. Resident #9 was equired total assistance of The resident had a rim a previous stroke and so of the right arm, at times, assed as 5' 9" tall and  analysis, dated 08/12/10, assessed the resident as at		MEASRUES OR SYSTEMIC OF PREVENT RECURRENCE:  Re-education was provided 9,9/20/10 and again 10/13/10 to and again 10/21/10 and 10/2 including nurse techs, med to and licensed nurses on consist care in accordance with each written plan of care to reinfor requirement to follow the plan of assistance for the provision and showers.  Education will be provided up staff including nursing assistated the same illensed nurses on residents' written plan of care reviewing the residents' NADI they are aware of the plan for provide care in a manner that residents' environment to be hazards as possible and to pradequate supervision and assavold accidents when possible.  HOW CORRECTIVE ACTIONS MONITORED:  Unscheduled observations of requiring assistance of more to showers to verify that assistance of the ND ate Sheet were conducted from 10/19/10 by designated in the QA committee Including the QA committee Including the DON, QA nurse, MDS coordinator, previous to recondinator.	/9/10 thru hru 10/16/10, 5/10 to staff schs, stently providing residents' ce the nned amount n of baths  on hire to ants, med i following the e and 6 daily so that r services to t allows the as free of ovide sistance to e.  WILL BE  residents than one for nce was jurse Aide om 9/17/10 nembers of ne ADON,		

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TREET ADDRESS, CITY, & TATE, ZIP CODE  SEE, THIRD STREET  RUSSELLVILLE, KY 42278    D	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/OLIA (X2) MULTIPLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			PLE GONSTRUCTION (X3) DA		DATE SURVEY COMPLETED		
OREEKWOOD PLACE NURSING R REHAB CENTER, INC  SUMMARY STATEMENT OF DEFICIENCIS PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIS (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR ISC DENTETTING INFORMATION)  F 323  Continued From page 9  using a shower bed.  A review of the nurses' note, dated 09/09/10 at 9:30 AM, revealed Licensed Practical Nurse (LPN) #2 was summoned to the shower boom and she observed Resident #9 lying on his/her back, on the flaor. Staff reported the resident had rolled off the shower bed. The resident's chin and right knee. Four staff members transferred to the resident to the facility's final investigation, dated O9/14/10, revealed CNA #4 was alone in the shower room providing Rosident #9 lying on his/her left side at the time. ONA #4 stated she felt the resident completance on the shower on the shower toom providing Rosident #9 shower on the shower bed. The CNA called for essistance and the DON and LPNs #1 and #3 responded. There were no completed by the DON. Prior to the fall, CNA #4 stated she received assistance from two other CNAs to			185313	B. WING	3		10.	14/2010
F 323 Continued From page 9  using a shower bed.  A review of the nurses' note, dated 09/09/10 at 9:30 AM. revealed Licensed Practical Nurse (LPN) #2 was summoned to the shower room and she observed Resident #9 lying on his/har back, on the flaor. Staff reported the resident had rolled off the shower bed. The resident was assessed as alert and verbal and a small abrasion was noted on the left side of the resident's chin and neuro-checks were initiated, which were within normal limits and the physician was notified. Further review of the nurses' note revealed the resident complained of chest pain at approximately 10:30 AM and was transferred to the hospital, for evaluation. The resident returned to the facility at approximately 11:20 PM.  A review of the facility's final investigation, dated 09/14/10, revealed CNA #4 was alone in the shower bed. The CNA had the shower bed move. The resident was positioned on his/her left side at the time. CNA #4 stated she felt the resident for to the initial assessment completed by the DON. Prior to the fall, CNA #4 stated she recoved assistance from two other CNAs to			REHAU CENTER, INC		683 E, THIRD	STREET		
A review of the nurses' note, dated 09/09/10 at 9:30 AM, revealed Licensed Practical Nurse (LPN) #2 was summoned to the shower room and she observed Resident #9 lying on his/her back, on the flaor. Staff reported the resident had rolled off the shower bed. The resident was assessed as allert and verbal and a small abrasion was noted on the left side of the resident's chin and right knee. Four staff members transferred the resident back to the shower bed, using a sheet.  The resident complained of a headache and nouro-checks were initiated, which were within normal limits and the physician was notified. Further review of the nurses' note revealed the resident complained of chest pain at approximately 10:30 AM and was transferred to the hospital, for evaluation. The resident returned to the facility's final investigation, dated 09/14/10, revealed CNA #4 was alone in the shower bed. The CNA had the shower bed positioned against the wall and felt the shower bed move. The resident was positioned on his/her left side at the time. CNA #4 stated she felt the resident spipling away from her and the resident felt to the floor onto his/her left side, between the wall and the back of the shower bed. The CNA called for assistance and the DON and LPNs #1 and #3 responded. There were no complainte of pain upon the initial assessment completed by the DON. Prior to the fall, CNA #4 stated she for received assistance and the ONA and LPNs #1 and #3 responded. There were no complainte of pain upon the initial assessment completed by the DON. Prior to the fall, CNA #4 stated she felt the received assistance and the ONA and LPNs #1 and #3 responded. There were no complainte of pain upon the initial assessment completed by the DON. Prior to the fall, CNA #4 stated she felt the received assistance and the ONA and LPNs #1 and #3 responded. There were no complainte of pain upon the initial assessment completed by the DON. Prior to the fall, CNA #4 stated she free the complainte of the pain and the pain and the pain and the pain and the	PREFIX	(EVCH DELICIENC,	MUST BE PRECEDED BY FULL	PREFIX		EACH CORRECTIVE ACTION 083-REFERENCED TO THE /	SHOULD BE	COMPLETION
shower bed. CNA #4 "thought" she could give the resident a shower without assistance and did not		A review of the nurses 9:30 AM, revealed Lid (LPN) #2 was summo she observed Resider on the floor. Staff report off the shower bed. The salert and verbal an noted on the left side right knee. Four staff resident back to the sident back to the sident complained on the left side resident complained on the resident complained of approximately 10:30 A the hospital, for evaluate to the facility at approximately 10:30 A review of the facility at approximately 10:30 A review of the facility 09/14/10, revealed CN shower room providing the shower bed. The positioned against the bed move. The resident slipping away fell to the floor onto his wall and the back of the called for assistance and #3 responded. The pain upon the initial as DON. Prior to the fall, received assistance for transfer the resident for shower bed. CNA #4	s' note, dated 09/09/10 at lensed Practical Nurse ned to the shower room and ht #9 lying on his/her back, orled the resident had rolled he resident was assessed d a small abrasion was of the resident's chin and members transferred the hower bed, using a sheet, led of a headache and tiated, which were within physician was notified. It was not feel the fichest pain at the and was transferred to ation. The resident returned stimately 1:20 PM.  It final investigation, dated the fall the shower bed wall and felt the shower bed wall and felt the shower had the stated she felt the from her and the resident sher left side, between the e shower bed. The CNA and the DON and LPNs #1 here were no complaints of sessment completed by the CNA #4 stated she om two other CNAs to om his/her chair to the "thought" she could give the	F	OA components of the continuous of the continuou	A nurse, MDS coordinator pment Coordinator will comply observe a minimum of some assist at unannor weeks, then a minimum of the second and the second accordinate when possible according with the shower is a conditional will be to verify the number of which the resident's when possible at the second according with the shower is and will be to verify the number of the will be proved the will be proved and duration of monit will be proved and seased.	er, and Staff continue to of ten (10) that require ounced times, on of ten (10) of time to listee,	10/26/10

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SYATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUI, TIPLE A. BUILDING	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		105313	B, WING		10	/14/2010	
	OVIDER OR SUPPLIER	& REHAB CENTER, INC	683 1	T ADDRESS, CITY, STATE, ZIP CODI E. THIRD STREET SELLVILLE, KY 42276	E		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 323	•	vas care planned for	F 323	; <del></del>			
	O9/09/10, revealed "Clavicular fracture." "Diagnostic Imaging "Fracture of the distals certainly possible, further elevation of the Acromion process." orthopaedic/neurosurevealed, "Shows qudistal end of the Cladobious AC joint."  An interview with CNAM, revealed she ar Resident #9 from his However, when askeneeded assistance with CNAs she could harknew the resident with transfers, but she was required in the shower check the care plan. The shower bed was sides of the shower resident's shower alignet felt she could have allowed the could have the could have the care plan. The shower bed was sides of the shower resident's shower alignet felt she could have the shower bed on the shower bed	gnostic Imaging," dated Findings suspicious for distal A review of follow-up " dated 09/16/10, revealed, al left Clavicle. AC joint injury If anything there has been the Clavicle in relation to the Further review of an orgical report, dated 09/29/10, restionable old fracture of the vicle with callus formation. No  IA #4, on 10/13/10 at 9:15 and two other CNAs transferred of the chair to the shower bed, and by the other CNAs if she with the shower, she told the didle it alone. She stated she has an assist of two staff with has unsure about assistance her. She stated she did not prior to providing the care. Is against the wall and both bed were lowered. The hy from her and fell to the he had not completed the one, prior to the incident. She					

CREEKWOOD PLACE

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

S FOR MEDICARE &	MEDICAID SERVICES				0.0938-0391
STATEMENT OF DEFIDIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185313		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		B. WNG _		10/1	14/2010
NAME OF PROVIDER OR SUPPLIER CREEKWOOD PLACE NURSING & REHAB CENTER, INC		,	883 E. THIRD STREET		1472010
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION		N SHOULD BE COMPLETION DATE	
An interview with LPN PM, revealed the resiplanned as a total assactivities of daily living him/herself. After the transferred back to be sent to the hospital at complaints of chest protocomplaints of chest protocomplaints of the left claw. An interview with the 10/14/10 at 10:45 AM the initial assessment resident did not complicated the hospital at due to complaints of claw to the hospital at due to complaints of claw to the hospital at due to complaints of claw to complete assist CNAs to review care part an interview with the accompleted after the restaff had not followed expected CNA #4 to redaily. As a result of the following the care plar sustained a fall, 483.65 INFECTION C SPREAD, LINENS  The facility must establification Control Prografe, sanitary and conto help prevent the deformation of the control of the cont	I #2, on 10/13/10 at 1:20 dent was assessed and care sist with all of his/her g, except for feeding fall, the resident was did; however, he/she was cout an hour later due to can. The resident returned de day with a possible vicie.  Director of Nursing, on grevealed she completed after the resident's fall. The lain of pain and there were flowever, the resident was cout an hour after the fall, hest pain. She stated CNA chance and she expected all collans every shift.  Administrator, on 10/14/10 at investigation was sident's fall and found the the care plan. She eview and follow care plans the CNA not reviewing or the resident had  ONTROL, PREVENT  Wilsh and maintain an team designed to provide a infortable environment and velopment and transmission in.		F441  It is the normal practice of Cree Piace Nursing and Rehab Centor	r to	
(a) Infection Control P	rogram	,			
	CONDER OR SUPPLIER  SUMMARY STY (EACH DEFICIENCY REGULATORY OR L  Continued From page An interview with LPN PM, revealed the resist planned as a total assessment to the hospital above to the facility the same fracture of the left clay.  An interview with the L  10/14/10 at 10:45 AM, the initial assessment resident did not compliants of chest part to the hospital above to the hospital above to complaints of clay.  An interview with the L  10/14/10 at 10:45 AM, the initial assessment resident did not compliants of clay.  An interview with the sent to the hospital above to complaints of clay.  An interview with the sent to the hospital above to complaints of clay.  An interview with the sent to the sent to the complaints of clay.  An interview with the sent to the completed after the restaff had not followed expected CNA #4 to redaily. As a result of the following the care plant sustained a fall, 483.66 INFECTION C SPREAD, LINENS  The facility must establinfection Control Prografe, sanitary and control help prevent the detof disease and infection of disease	TOOD PLACE NURSING & REHAB CENTER, INC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 11  An interview with LPN #2, on 10/13/10 at 1:20  PM, revealed the resident was assessed and care planned as a total assist with all of his/her activities of daily living, except for feeding him/herself. After the fall, the resident was transferred back to bed; however, he/she was sent to the hospital about an hour later due to complaints of chest pain. The resident returned to the facility the same day with a possible fracture of the left clavicle.  An interview with the Director of Nursing, on 10/14/10 at 10:45 AM, revealed she completed the Initial assessment after the resident's fall. The resident did not complain of pain and there were no apparent injuries. However, the resident was sent to the hospital about an hour after the fall, due to complaints of chest pain. She stated CNA #4 had available assistance and she expected all CNAs to review care plans every shift.  An interview with the administrator, on 10/14/10 at 2:30 PM, revealed an invostigation was completed after the resident's fall and found the staff had not followed the care plan. She expected CNA #4 to review and follow care plans daily. As a result of the CNA not reviewing or following the care plan, the resident had sustained a fall.  483.66 INFECTION CONTROL, PREVENT	(X2) PROVIDER STORMED IN THE PROVIDER SUPPLIER CLIN IDENTIFICATION NUMBER:  185313  (INCOMIDER OR SUPPLIER  DOD PLACE NURSING & REHAB CENTER, INC  SUMMARY STAYEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 11  An interview with LPN #2, on 10/13/10 at 1:20  PM, revealed the resident was assessed and care planned as a total assist with all of his/her activities of daily living, except for feeding him/herself. After the fall, the resident was sant to the hospital about an hour later due to complaints of chest pain. The resident returned to the facility the same day with a possible fracture of the left clavicle.  An interview with the Director of Nursing, on 10/14/10 at 10:45 AM, revealed she completed the initial assessment after the resident's fall. 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DE DERICIENCIES CORRECTION  (X1) PROVIDER DIRECTION NUMBER: 185313  DOD PLACE NURSING & REHAB CENTER, INC  SUMMARY STAYEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC DENTIFYING INFORMATION)  COntinued From page 11  An Interview with LPN #2, on 10/13/10 at 1:20 PM, revealed the resident was assessed and care planned as a total assist with all of hie/her activities of daily living, except for feeding him/herself. After the fall, the resident returned to the facility the aeme day with a possible fracture of the laft clavicle.  An Interview with the Director of Nursing, on 10/14/10 at 10:45 AM, revealed she completed the initial assessment after the resident seal to the hospital about an hour later due to complaints of chest pain. She stated CNA #4 had available assistance and she expected all CNAs to review care plans every shift.  An interview with the administrator, on 10/14/10 at 2:30 PM, revealed an investigation was completed after the resident's fall and found the slaff had not followed the care plans every shift.  An interview with the administrator, on 10/14/10 at 2:30 PM, revealed an investigation was completed after the resident's fall and found the slaff had not followed the care plans. He resident had sustained a fall.  433.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	SECOR MEDICARE & MEDICAID SERVICES OPERIORIOS OPERIORIO

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SE COMPLE	
	185313			10/	14/2010
NAME OF PROVIDER OR SUPPLIER CREEKWOOD PLACE NURSIN	IG & REHAB CENTER, INC	68	EET ADDRESS, CITY, STATÉ, ŽIP COD 3 E, THIRD STREET JSSELLVILLE, KY 42278		
PREFIX (EACH DEFICI	ENCY MUST BE PRECEDED BY FULL	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFIDIENCY)			(XS) COMPLETION DATE
The facility must of Program under will investigates, of In the facility;  (2) Decides what should be applied (3) Maintains a response related to (b) Preventing Sp. (1) When the Inferdetermines that a prevent the spreasisolate the resider (2) The facility must communicable disfrom direct contact will (3) The facility must hand washing is in professional pract.  (c) Linens Personnel must have transport linens so infection.  This REQUIREMED by: Based on observation record reviews, it failed to ensure steach direct reside handwashing was	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 12  The facility must establish an infection Control Program under which it - (1) Investigates, controls, and prevents infections In the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.  This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, it was determined the facility failed to ensure staff washed their hands after each direct resident contact for which handwashing was indicated for two residents (#1 and #6), in the selected sample of 19.		CORRECTIVE ACTION FOR AFFECTED BY THIS PRACT  Staff identified as not washi while caring for residents (# provided re-education on 10 Administrator on washing the each direct resident contact proper hand hygiene practices after each direct refor residents (#1 and #6).  HOW OTHER RESIDENTS I POTENTIAL TO BE AFFECT IDENTIFIED:  All residents were identified staff wash their hands after resident contact, therefore a provided re-education on ha described below.  MEASURES OR SYSTEMIC PREVENT RECURRENCE:  Re-education was provided to Administrator and Staff Deve Cogrdinator to staff including nurse techs, and 10/13/10, 10/14/10, 10/15/11/10/21/10, and 10/25/10 relativeshing their hands after eadirect resident contact.  Further re-education related requirement of following prohygiene practices after resident contact.  Further re-education related requirement of following prohygiene practices after resident including nursing assist medication aides, and ilcens previously re-educated on et dates. This re-education will staff Development Coordinal	ing their hands thand #6) were 0/13/10 by the neir hands after thands after thands after thand following ces. HAVING THE TED WERE  as requiring each direct all staff were and washing as  CHANGES TO  by the elopment change ilicensed nurses 0, 10/16/10, ted to staff ch to the per hand lent contact 11/12/10 to conts, red nurses not ardier mentloned the done by the	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SE COMPLE	
		185313	9. WING		10/	1 <i>41</i> 2010
NAME OF PROVIDER OR SUPPLIER  CREEKWOOD PLACE NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE  683 E, THIRD STREET  RUSSELLVILLE, KY 42276			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X6) COMPLETION OATE	
F 441	Continued From page	13	F 441			
	Control*, which was to important way to previous handwashing. The before and after residence used.  1. A record review reviadmitted to the facility diagnoses to include it and the facility diagnoses to include it and the facility diagnoses to include it and facility diagnoses to include and facility diagnoses to include it and facility diagno	Pressure Ulcer, Urlnary espiratory System Disease.  y Minimum Data Set (MDS), the facility identified ively independent and sistance with bed mobility DS revealed the resident neter and was incontinent of provision of wound/catheter: 00 PM, revealed Licensed #1 did not wash his hands, s. After care was provided e (CNA) #1, who did not sted gloves before touching resident's room. For e control to lower the dithe resident's bedside resident's linen on the bed		HOW CORRECTIVE ACTIONS of MONITORED:  A 10% sample of residents will is selected by the QA committee of seven (7) days, then weekly for weeks, and then monthly for a clime to be determined by the QD basked on findings of previous is hand washing observations. The include residents on all units, D from the QA committee including the ADON, QA nurse, DON, and Development Coordinator will reobserve staff members on each shift providing care to the samp to verify that staff are following hygiene practices after each directive to the contact.  The QA Committee may increase frequency or duration of observe concerns are identified. Converses of concern are identified frequency and duration of monitor decreased.	be daily for three (3) duration of A committee review of a sample will esignees ng Staff andomly ble of residents appropriate hand rect resident se the ations if resely, if no the	11/13/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION . A, BUILDING		(X3) DATE SURVEY COMPLETED	
	. 185313		B, WING		10/14/2010	
NAME OF PROVIDER OR SUPPLIER  CREEKWOOD PLACE NURSING & REHAB CENTER, INC		STREET ADDRESS, CITY, STATE, ZIP CODE  893 E. THIRD STREET  RUSSELLVILLE, KY 42278				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SHI TAG CROSS-REFERENCED TO TME APP DEFICIENCY)		CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 441	stated, "I usually do."  2. A record review revadmitted to the facility the quarterly MDS, data facility identified Residudependent and required by the mobility.  An observation of the 10/13/10 at 9:40 AM, the resident's coccyx needed a Q-tip to me Aide (NA) #1 remover room and obtained a hands. LPN #1 remover oom without washing #1 returned to the reswithout washing their After provision of care hallway and retrieved while wearing the concentration of the room of the removed her gloves and interview with LPN PM, revealed he did removing his soiled go An interview with NA revealed she should here.	realed Resident #6 was on 07/14/10. A review of sted 08/26/10, revealed the dent #6 as cognitively lired extensive assistance  provision of wound care, on revealed LPN #1 cleansed wound and then realized he asure the wound. Nurse d her gloves and left the Q-tip without washing her ved his gloves and left the his hands. NA #1 and LPN ident's room, donned gloves hands and provided care. NA #1 walked out into the the resident's wheelchair, itaminated gloves. She with the wheelchair, ind washed her hands.  #1, on 10/13/10 at 1:10 not wash his hands after	F 441	OEFICIEN	NUT)	
	10/14/10 at 9:55 AM. their hands before pro	Director of Nursing, on revealed staff should wash oviding resident care and olled gloves. She expected	: :	:. 		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/27/2010 FORM APPROVED OMB NO. 0938-0391

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185313		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
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NAME OF PE	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
CREEKW	OOD PLACE NURSING E	REHAB CENTER, INC		1	83 E. THIRD STREET		
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F 441	Continued From page	e 15	F	441			-
	staff to follow the faci	lity policy for handwashing.					
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FORM CM8-2567(02-99) Previous Versions Obsolete

Event ID: UK4Z11

Facility ID: 100299

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If continuation sheet Page 16 of 16

PRINTED: 10/27/2010 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES TOATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES 01 - MAIN BUILDING 01 IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 10/14/2010 B. WING 185313 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 683 E. THIRD STREET CREEKWOOD PLACE NURSING & REHAB CENTER, INC. RUSSELLVILLE, KY 42276 COMPLETION (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE & 10 SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID TAG REGULATORY OR USC IDENTIFYING INFORMATION) PREFIX DEFICIENCY) TAG K 000 INITIAL COMMENTS K 000 K1.47 A Life Safety Code Survey was conducted on It is the normal practice of Creekwood 10/14/10 to determine Federal compllance with Place Nursing and Rehab for electrical Title 42, Code of Federal Regulations, 482.41 (b) wiring and equipment to be in accordance with NFPA 70, National (Life Safety from Fire) and found the facility not in Electric Code .9.1.2. relating to ground compliance with NFPA 101 Life Safety Code fault protection for all electrical 2000 Edition. Deficiencles were cited with the receptacles near a water source. highest deficiency at an D. K 147 K 147 NFPA 101 LIFE SAFETY CODE STANDARD CORRECTIVE ACTION FOR RESIDENTS \$S=D Electrical wiring and equipment is in accordance AFFECTED BY THIS PRACTICES with NFPA 70, National Electrical Code, 9.1.2 10/15/10 The light fixture located over the sink in the bathroom of Resident Room # 114 was removed. This STANDARD is not met as evidenced by: HOW OTHER RESIDENTS HAVING THE Based on observation and staff interview, the POTENTIAL TO BE AFFECTED WERE facility failed to ensure compliance with NFPA 70 IDENTIFIED: National Electric Code 1999 Edition relating to All other electrical receptacles near water ground fault protection for all electrical sources were checked to ensure compliance with NFPA 70 National Electric Code 9.1.2 receptacles near a water source. This condition relating to ground fault protection for affected two residents. electrical receptacles near water sources. Receptacles not in compliance with this code Examples include: were removed. During the Life Safety Code Inspection tour conducted, on 10/14/10 at approximately 10:00 MEASURES OR SYSTEMIC CHANGES TO AM, a light fixture located over the sink in the PREVENT RECURRENCE: bathroom of Resident Room #114 was observed to have a 125 volt receptacle which was not Education was provided to maintenance ground fault protected (GFCI). staff on 10/13/10 relating to all electrical receptacles near water sources requiring An interview with the Director of Maintenance at ground fault protection. this time revealed he was aware that some of the Any electrical receptacles installed near water sources will be checked by light fixtures contained a receptacle, but had not Maintenance staff to verify ground fault thought about them not being ground fault protection and compliance with NFPA 70, protected. National Electric Code 9.1.2. TITLE LABORATORY DIRECTOR'S OR PROVIDENSUPPLIER REPRESENTATIVE'S SIGNATURE

Any deficiency statement ending with an esterisk (\*) denotes a disciency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the share findings and plans of correction are disclosable 14 following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction is requisite to continued days following the date these documents are made available to the facility. If deficiencies are clied, an approved plan of correction is requisite to continued program participation.

FORM CM5-2567(02-99) Previous Versions Obsoleia

Event ID: UK4Z21

Facility ID: 100299

If continuation sheet Page 1 of 2

PRINTED: 10/27/2010 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) OATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLÍA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: 01 - MAIN BUILDING 01 A. BUILDING AND PLAN OF CORRECTION 10/14/2010 185313 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 683 E. THIRD STREET CREEKWOOD PLACE NURSING & REHAB CENTER, INC RUSSELLVILLE, KY 42276 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG K 147 Continued From page 1 K 147 HOW CORRECTIVE ACTIONS WILL BE MONITORED: Reference to: NFPA 70 National Electric Code 1999 Edition After completion of repairs, rounds will be 210-8. Ground-Fault Circuit-Interrupter Protection conducted by the Administrator or Maintenance Director annually to verify for Personnel that all electrical receptacles installed (a) Dwelling Units. All 125-volt, single-phase, 15near water sources are equipped with ground fault protection. Any electrical repairs completed on receptacles near a water source will be reviewed by the and 20-ampere receptacles installed in the tocations specified below shall have ground-fault circuit-interrupter protection for personnel. Director of Maintenance to verify that it has ground fault protection on an ongoing basis. 1. Bathrooms.

FORM CMS-2587(02-99) Previous Vereiona Obsoleia

Event ID: UK4Z21

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If continuation sheet Page 2 of 2